

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010409</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/22/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>KEYSTONE WOODS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2335 N MADISON AVE ANDERSON, IN 46011</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Licensure Survey.</p> <p>Survey Dates: May 21, 22, 2012</p> <p>Facility Number: 010409 Provider Number: 010409 AIM Number: N/A</p> <p>Survey Team: Tammy Alley RN Toni Maley BSW (May 22, 2012)</p> <p>Census Bed Type: Residential: 56 Total: 56</p> <p>Census Payor Type: Other: 56 Total: 56</p> <p>Sample: 7</p> <p>Keystone Woods was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey.</p> <p>Quality review 5/22/12 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1